ZOOMING IN ON UNGASS

Monitoring National Progress in the Implementation of the UNGASS Outcome Document (2019-2029)

DRUG POLICY FUTURES

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Published by: Drug Policy Futures April 2021
www.drugpolicyfutures.org

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Can be downloaded from www.drugpolicyfutures.org

EXECUTIVE SUMMARY

As concerned civil society organisations from all corners of the world and affiliated to the global network Drug Policy Futures (DPF), we consider the 2016 UNGASS outcome document as an excellent menu for broad, balanced and evidence-based national drug policies. The critical issue now is to what extent the consensus from UNGASS and the broad menu of suggested interventions in the outcome document are reflected policy documents and practical interventions in the Member States.

To contribute in the follow-up process Drug Policy Futures has embarked on a project to monitor the Member States' implementation of their joint commitment to effectively addressing and countering the world drug problem. We have looked at 15 selected countries and used a set of 25 indicators from 13 action areas that we appeal to governments to prioritize.
In general, in the countries that are part of the monitoring exercise, we thus far see few signs that the UNGASS consensus has had a direct impact on national drug policies.

We recognize of course the possibility that changes have been made on a more operational level than what our indicators have been able to uncover. We must also remember that the data for the report encompasses only the three-four first years after UNGASS. This is why Drug Policy Futures has committed itself to monitor UNGASS follow-up at least two more times before the end of the implementation decade (2029). This means that the volume of data on the implementation of the agreements in the UNGASS outcome document will grow and become more comprehensive in the years ahead, providing us with the opportunity to monitor and advise on the way forward in reducing the world's drug problem.

Eight action areas have been included in this first round of monitoring. For each of the areas we have made an assessment of the implementation in 14 UN Member States and the State of Florida (in the US). In order to improve the follow-up of UNGASS, we have also included our recommendations to Members States under each of the areas:

Recommendations

1. NATIONAL POLICIES

Adopt a national, overarching drug policy document and revise this with regular intervals;

Domesticate the most relevant recommendations from UNGASS in national policies.

2. REDUCE DRUG USE PREVALENCE

Define explicitly in national drug policies that reducing drug use prevalence or keeping these figures low is an overarching goal for policies and interventions;

Establish monitoring systems for regular tracking of possible changes in prevalence figures or drug consumption patterns. Such systems should preferably have data for last year's use, regular use and heavy use.

3. INVEST IN PREVENTION

In the era of the Sustainable Development Goals, make primary prevention the highest priority in national drug policies as it is ethically right, scientifically sound and economically smart;

Use the International Standards on Drug Use Prevention to select the most effective interventions and thereby improve national prevention efforts;

Allocate long-time funding for prevention programmes to ensure that they become sustainable over time. Prevention takes time, simply;

Benefit from the competence that civil society organisations have in mobilizing communities and individuals and also benefit from good prevention programmes developed by these organisations.

4. PARENTS FOR PREVENTION

Make mobilization of and support to parents a central part of national drug policies;

Establish a national programme and a national unit/clearinghouse for support to local parent initiatives;

Integrate mobilization of parents as an important element in broader community programmes for protection of children and youth;

Draw lessons from the many NGO programmes for good parenting and collaborate with these NGOs.

5. MOBILIZE COMMUNITIES

Define community mobilization as a priority in national policies, not only to combat drug problems but also to reduce other risk behaviours among adolescents;

Establish a national clearinghouse or resource unit that can support local communities in various ways;

Draw experiences from NGOs and Member States that have developed good models for forming and running local coalitions for drug prevention.

6. SUPPORT SELF-HELP GROUPS

Integrate self-help groups in the system of community-based treatment and care;

Recognize and define self-help groups in national drug policies and strategies;

Enable access to quality-assured self-help groups by publishing an updated list of organisations and institutions providing self-help group services;

Provide financial and technical support for organisations/institutions that offer self-help support to people who use drugs or who are in recovery, and to their families.

7. FOCUS ON THE SPECIAL NEEDS OF WOMEN

Take women's needs and roles into account as a cross-cutting issue in all drug policy areas; prevention, treatment and recovery;

Address properly, both in policy and in specific interventions, women's needs as family members of drug users;

Include women in policy-making, implementation and evaluation of drug policies and programmes.

INTRODUCTION

BACKGROUND

In April of 2016 the UN Member States gathered for the United Nations General Assembly Special Session (UNGASS) on the world drug problem. The outcome document titled "Our joint commitment to effectively addressing and countering the world drug problem"[1] offers an excellent menu for a comprehensive, balanced and effective policy to reduce drug use and its related harm in the world.

Drug Policy Futures, a broad global network of civil society organisations and individuals, fully supports the approach to drug policy in the UNGASS outcome document. In order to reduce drug-related harm Member States need to implement drug strategies that are integrated, multidisciplinary, mutually-reinforcing, balanced, evidence-based, and comprehensive.

The Member States' national follow-up of all the good intentions and ideas from UNGASS is the critical issue now. We, Drug Policy Futures, therefore commend the Commission on Narcotic Drugs for defining the years from 2019 to 2029 as a decade of implementation. To contribute we have embarked on a project to monitor the Member States' implementation of their commitment to effectively addressing and countering the world drug problem.

AIMS

This report is the first of several where we

- ask how and to what extent selected Member States follow up in practice the good intentions in the UNGASS outcome document.
- make recommendations to Member States on the national follow-up.

FOCUS AREAS AND INDICATORS

In 2019 (revised in March 2020) Drug Policy Futures published the report "People's Voice; the roar of the silent majority "[2]. "People's Voice" recommends 13 focus areas for governments in their follow-up of UNGASS. In the monitoring project we used these 13 areas. We also included an overarching action area (No.1) to be able to document the existence, content and scope of national drug policies and strategies, and an action area 15 to assess whether knowledge on drugs and drug use prevention is part of training programmes for professional groups. The 15 action areas are:

1. National policies to guide work to reduce drug-related harm.
2. Reduce drug use prevalence.
3. Invest in prevention.
4. Mobilize communities
5. Prioritize early intervention and assistance to vulnerable groups.
6. Prioritize screening and brief interventions.
7. Offer treatment, rehabilitation, and harm-reduction options.
8. Foster reintegration of people with drug problems.
9. Support self-help groups for drug users and people in recovery.
10. Social programs = effective drug policy programs.
11. Support alternative development.
12. Develop and implement alternatives to incarceration.
13. Implement the principle of proportionality in sanctions.
14. Focus on the special needs of women.
15. Capacity building.

For this monitoring project we developed 25 indicators[3] from the 15 focus areas in order to study the follow-up of the Member States. Drug policy organisations in a selected number of countries serve as National Focal Points in this monitoring exercise. These NGOs have volunteered to contribute by monitoring national policy processes in their respective countries. The 15 action areas and the 25 indicators have been used by the

National Focal Points to collect data on the situation. in their respective countries. The data collection period ended in July 2020. These national data have been assembled and made into this report by a Drug Policy Futures editorial group.

In this first report we cover six of the action areas: 1, 2, 3, 4, 9 and 14. Area 3 has been given two chapters (chapters 4 and 5). We plan to make at least two more reports before the end of the defined implementation decade in 2019 - 2029. For these reports more action areas will be included.

THE COUNTRIES

14 Member States and the State of Florida in the US (all 15 are named "countries" in the report) have been in focus in this first monitoring report. They are, in alphabetical order: Democratic Republic of Congo, Florida, Ghana, India, Italy, Kenya, Nepal, Nigeria, Norway, Pakistan, Sri Lanka, Sweden, Uganda, USA and Zambia. New countries may be added in later reports.

We have not aimed at including a representative selection of countries for the study. The selection is a consequence of where DPF had national affiliates that were able to take on the role as National Focal Points. The result is a selection of countries that have different approaches to drug policy, some are small, others are large, some are countries from the Northern hemisphere and some are from the Southern hemisphere.

Some countries have been more difficult to assess than others. This is especially the case for countries with federal systems like the United States and India, where there are considerable variations between the different states within the country. In these cases, we have primarily focused on policies on the federal level, something that will clearly not give a full and correct picture of the situation on the ground in each of the states. The exception is Florida.

In the report we have mainly covered what governments are doing as follow-up of UNGASS, as they are the signatories to the UN documents. Drug policies are of course also relevant to the work of other stakeholders other than governments. However, this is only partly reflected in our assessments. It would be too demanding to map all actions by all relevant civil society stakeholders in so many countries since they are so many and often only locally based. They are also seldom coordinated through one national unit, and their actions are not covered in one national document.

THE SCOPE

Drug policy is a complex issue that overlaps with many other policy fields and the political situation is different from one country to the other. A limited number of indicators cannot grasp the full and nuanced picture of the drug policy situation in a country. But we hope that our monitoring exercise still can document interesting trends and examples from Member States, and in best case also document improvements in national drug policies in the years leading up to 2029. We make recommendations under each action area to improve the Member States' chances in reducing drug-related harms in their countries.

The intention of the report is not to blame and shame countries. Instead we have highlighted some countries and some examples that could be inspiring for other countries, without concluding that these countries are champions in drug policy. There is more to gain from inspiration than competition between countries. In any case, there is large room for improvements in drug policies in all the 15 countries in this report, and the same is most likely the case for the other around 185 countries of the world.

KEY DOCUMENTS

UNGASS Outcome Document

Ministerial Declaration on strengthening our actions at the national, regional and international levels to accelerate the implementation of our joint commitments to address and counter the world drug problem (2019)

International Standards on Drug Use Prevention

People's Voice, The roar of the silent majority

NATIONAL POLICIES

INTRODUCTION

The UNGASS outcome document recommends Member States to apply "an integrated, multidisciplinary, mutually reinforcing, balanced, scientific evidence-based and comprehensive approach"[4] to reducing drug-related harm. The approach should include

> "prevention, early intervention, treatment, care, recovery, rehabilitation and social reintegration measures, as well as initiatives and measures aimed at minimizing the adverse public health and social consequences of drug abuse"[5].

This continuum of interventions is essential. No silver bullets exist. The global drug problem is a complex issue with a wide spectrum of both root causes and negative consequences for individuals, families and nations. An effective national drug policy needs to be equally comprehensive.

In order to secure such a comprehensive approach Member States should have a national drug policy document; an overarching document that defines targets and action areas, outlines key interventions in each of the areas and shows how interventions should interact and create synergies. Such documents must be reviewed and revised at regular intervals in order to incorporate new knowledge and adjust policies as a consequence of achieved results or lack of results.

Some people claim that everything has been tried in drug policies and that nothing works. That is simply not true. Many interventions do work. The problem is that most of them are not used by governments in a systematic and concerted manner. The UNGASS 2016 outcome document offers an excellent opportunity to create or update national strategies, including to link national drug policies to the ambitious targets in the Sustainable Development Goals.

In this chapter

We ask:

Do Member States have overarching national drug policy documents and have the policies been updated with input from the UNGASS outcome document?

NATIONAL POLICIES

FINDINGS

Three countries have a national drug policy/master plan adopted after UNGASS 2016; Pakistan (2019), India (2018) and USA (2020).

Sri Lanka released its national policy for prevention and control of drug abuse in 2016. Sweden has a national strategy for alcohol, narcotic drugs, doping and tobacco from 2016. The same is the case for DR Congo, but this plan however covers only five regions of the republic.

Three countries report to have a new national drug policy in the making: Kenya, Zambia and Uganda. This gives these countries the possibility to pick the most relevant options from the UNGASS Outcome Document and include in their new national policy documents.

The following countries have national drug policies or strategies that date some time back; Italy (2013), Nepal (policy for drugs control from 2006 and a drugs control strategy from 2010) and Nigeria (2015).

Norway does not have an explicit drug policy document. Instead, drug policies are updated by government white papers that are discussed by parliament at some years intervals, the most recent is from 2015.

Ghana has no national drug policy document, but a law on narcotic drugs from 1990 which provided for the establishment of the Narcotics Control Board.

This leads us to conclude that Member States covered in the project have so far (by July 2020) only to a limited degree used UNGASS 2016 as an opportunity to review and develop their national drug policies. However, most of the 15 countries seem to have a comprehensive and balanced approach to reducing drug-related harm, in the sense that the national documents address the broad continuum of interventions including prevention, early intervention, treatment, recovery and health care for problem users. However, we have not tried to document whether this comprehensive approach is reflected also in practical action or if countries choose to prioritize only some selected interventions.

Recommendations

In order to improve the follow-up of UNGASS all Member States should:

- **Adopt a national, overarching drug policy document and revise this with regular intervals;**
- **Domesticate the most relevant recommendations from UNGASS in their national policies.**

REDUCE DRUG USE PREVALENCE

INTRODUCTION

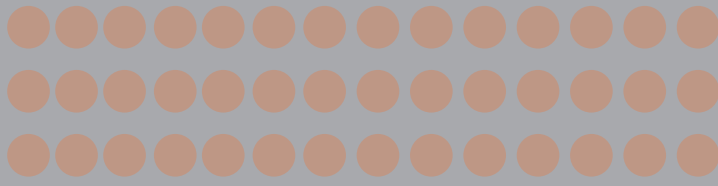
Figures for prevalence of illegal drug use in a country or in a community is one of the most powerful tools to track changes in the drug problem and to monitor results of policies and interventions.

The World Drug Report 2020 estimates that around 95 per cent of the world's adult population (15-64 years) do not use illegal drugs, and that there has been only a very minor increase in users over the last ten years[6]. This means that the use of illegal drugs is still strikingly low and that the prevalence figures have been more or less uninfluenced by all the technological, cultural and political changes that we have seen in the world, and also by the massive propaganda push in many regions towards making drug use more normal and accepted.

However, the 2020 issue of the World Drug Report points at the worrying trend that drug use during the last two decades has been increasing faster in developing countries than in more wealthier parts of the world. This can partially be explained by a strong growth in the younger populations in the Global South, as well as a rapid urbanization in many of these countries. At the same time, within countries, the richer populations segments have a higher prevalence of drug use, while the poorer and marginalized groups still suffer the most severe consequences of drug use.

One of the conclusions in the World Drug Report 2020 is that the drug situation is becoming increasingly complex, a fact that inevitably raises new challenges for national drug policies.

The World Drug Report offers a number of statistical annexes with prevalence figures from all UN Member States; figures for the general population as well as for adolescents. Data for different types of substances also exist. However, the prevalence figures for many countries date many years back, in some cases back to the early 2000s. Few countries have reported very updated figures. It goes without saying that prevalence data from 10-15 years back do not offer much guidance for monitoring developments and adjusting policies.



REDUCE DRUG USE PREVALENCE

The UNGASS Outcome Document and also the 2019 Ministerial Declaration from The Commission on Narcotic Drugs[7] address drug use prevalence typically as an issue of both drug demand and drug supply reduction. In relation to this, drug policy can draw on important lessons learned from many decades of alcohol policy. Modern alcohol policy, as recommended by WHO and documented in the research monograph ***Alcohol No Ordinary Commodity***[7], is based on the so-called "total consumption model". This approach was first developed in the mid-1970s and later refined and confirmed by research from many countries and cultures.

The basic assumption of the total consumption model is that the total consumption level in a given population to a large extent decides the level of alcohol-related harm.

For obvious reasons, consumption figures are not as readily available for illegal drugs as for alcohol. Still there are good reasons to assume that the same mechanisms operate for illegal substances too, in spite of some important differences. Alcohol use and drug-taking are basically collective behaviours in the sense that they are learned behaviours, formed by the people and culture that surround us.

This means that the consumption level is obviously not the only factor of importance. Consumption patterns also matter; i.e. how a substance is used, in what settings, by which groups. Also socio-economic conditions play a role. From alcohol we see that alcohol use in a poor and marginalized population creates "more harm per liter" than the same amount consumed in wealthier groups. And finally, individual factors also seem to influence the consequences of drinking; mental health, traumas, genetics etc.

Regular monitoring of drug use prevalence can give early warnings of changes in drug consumption. Prevalence figures can also show in which population groups drug use is most prevalent, which substances that are most used and if there are important differences between age groups, geographic areas, gender etc.

REDUCE DRUG USE PREVALENCE

"Availability" is a key concept in reducing alcohol and drug use. However, availability must be understood as a many-sided phenomenon. The book ***Drug policy and the public good***[8] points at four elements of availability. These are elements that interact with each other and influence consumption levels and patterns: 1) Physical availability; how easily accessible the various substances are; 2) Social availability; how accepted drug use is in your culture or population group; 3) Psychological availability; how attractive the drugs appear to various people; 4) Economic availability; what is the real price of a drug; price compared with purchasing power in a population.

The four aspects of availability are influenced by social, cultural and economic developments in a society. But they can also be influenced by political decisions, legislation and interventions, and this is the essence of drug policies that prevent harm at the earliest possible stage: How can drug use be made less attractive in a population and in particular among the most vulnerable groups; adolescents most of all?

The UN drug conventions are from the outset based on a public health and a total consumption model, well before the "total consumption model" was introduced as a scientific concept in the alcohol policy field. This means that the conventions prescribe for the Member States to use universal prevention efforts to reduce drug demand and drug supply in a coordinated manner. This will lead to a reduction in drug consumption and, consequently, in levels of drug-related harm on individuals and the society. Universal populations-based prevention efforts must, nevertheless, be supplemented with treatment and rehabilitation of people with drug-related problems.

In this chapter

We ask:

Is low or reduced drug use prevalence defined as a priority and an explicit target for national drug policies, and are there systems in place to monitor developments in prevalence figures?

REDUCE DRUG USE PREVALENCE

FINDINGS

Our material suggests that none of the 15 studied countries have a stringent and well-developed system where prevalence data are collected regularly and then systematically used for developing or adjusting policies.

Three countries are reported to have a structured system for collecting drug use prevalence data at regular intervals, in particular from the youth population. Three additional countries have similar surveillance systems but with a time lag of two-three years from the time of collection till the material is published. This reduces the value of the data for policy adjustments. Three countries appear to have monitoring systems for drug use prevalence in the making.

Recommendations

In order to improve the follow-up of UNGASS all Member States should:

- **Define explicitly in their national drug policies that reducing drug use prevalence or keeping these figures low is an overarching goal for policies and interventions;**
- **Establish monitoring systems for regular tracking of possible changes in prevalence figures or drug consumption patterns. Such systems should preferably have data for last year's use, regular use and heavy use.**

INVEST IN PREVENTION

INTRODUCTION

Primary prevention has repeatedly been defined as a key tool to reduce drug-related harm. This was the message from the UNGASS in 2016 as well as in the Joint Ministerial Statement in the Commission on Narcotic Drugs in 2019 and in the International Standards on Drug Use Prevention.

Preventing problems from occurring or expanding is by far the best approach to reducing drug-related harm, especially in the era of sustainable development. Evidence-based prevention holds four major benefits: it is cost-effective, it is sustainable, it develops people and community empowerment, and it is human rights-based.

Many paragraphs in the UNGASS outcome document call on Member States to put resources into primary prevention, including these two:

> "Take effective and practical primary prevention measures that protect people, in particular children and youth, from drug use initiation by providing them with accurate information about the risks of drug abuse, by promoting skills and opportunities to choose healthy lifestyles and develop supportive parenting and healthy social environments and by ensuring equal access to education and vocational training".

> "Increase the availability, coverage and quality of scientific evidence-based prevention measures and tools that target relevant age and risk groups in multiple settings, reaching youth in school as well as out of school, among others, through drug abuse prevention programmes and public awareness-raising campaigns, including by using the Internet, social media and other online platforms, develop and implement prevention curricula and early intervention programmes for use in the education system at all levels, as well as in vocational training, including in the workplace, and enhance the capacity of teach ers and other relevant professionals to provide or recommend counselling, prevention and care services"[10].

The International Standards on Drug Use Prevention conclude that substance use disorders are fully preventable and treatable through the use of evidence-based prevention programmes, both universal programmes and interventions targeted at vulnerable groups and individuals. The Standards summarize the currently available scientific evidence, describing interventions and policies that have been found to result in positive prevention outcomes and their characteristics.

INVEST IN PREVENTION

The Standards also identify the major components and features of an effective national drug prevention system. As such, the Standards provide compelling guidelines to assist policy makers worldwide to develop programmes, policies and systems that are a cost-effective investment in the future of children, youth, families and communities.

In a number of public presentations of the International Standards, UNODC representatives have reported that for every dollar or euro spent on prevention, at least ten can be saved in future health, social and crime costs. In addition to the economic aspect, it should also be underlined that primary prevention of risky behaviours like drug use is an essential part of giving children and youth the framework to reach their full potential as individuals and community members.

In this chapter

We ask:

To what extent do Member States give primary prevention a prominent place in their national drug policies?

FINDINGS

The national reports show that all countries in this monitoring exercise have defined primary prevention as a priority in their drug policies. Countries have chosen different ways and different documents to express this. Our assessment cannot tell to what extent political declarations have materialized in the form of practical programmes and intervention or which types of prevention efforts the various countries have chosen.

All countries have, one way or the other, allocated funds for prevention efforts. In many cases this has been in the form of specific budget lines for prevention while other countries have "hidden" their prevention allocations in more general health, social services, education or police budget lines. Many of our national focal points however describe their country's spending for prevention as too small, only short-term, inadequate, poor, not at a large enough scale, reduced over time etc.

All countries appear to have established national government institutions with the mandate to follow up drug policy, prevention and treatment. There are, however, large variations in how this is solved; name of the institutions, scope of work, position in the government hierarchy etc. This probably reflects varying models for government administration, but also which approach a country takes to drug issues. In earlier days drugs were often considered a police and security issue, while we now see more and more countries shifting into a health and social welfare approach to drugs. It would be interesting to study if this shift also has resulted in new administrative solutions.

We have found that seven of the countries have made references to the International Standards on Drug Use Prevention in policy documents and plans; Kenya, Nigeria, Norway, Pakistan, Sri Lanka, Zambia and Uganda. Some countries have also worked together with UNODC to develop their preventions programmes.

There is a substantial number of examples of good prevention programmes around the world carried out by governments and civil society organisations. The degree of collaboration between government institutions and NGOs seem to vary considerably between countries, also between neighbouring countries with the same political systems and traditions. Many of the prevention programmes focus on reducing known risk factors for substance use and strengthening a broad range of parental, school and community protective factors.

As expected, schools programmes on illegal drugs or substance use more in general are found in all countries. At the same time, several countries have not given substance use prevention a formal and specific place in curriculums for students or in teachers' training. In many cases school programmes originate from local initiatives by concerned teachers or headmaster, parents or local NGOs. This can be considered a strength in itself as it may release local engagement. On the other hand, there is a risk that such programmes do not build on the international evidence-base on effective drug prevention.

Some countries have chosen to integrate substance use prevention in broader and more general prevention efforts, life-skills programmes etc. Such a solution falls well in line with the recommendations from the International Standards on Drug Use Prevention, but the risk is that specific issues like drugs or alcohol are being downplayed or ignored for various reasons.

INVEST IN PREVENTION

Recommendations

In order to improve the follow-up of UNGASS all Member States should:

- **In the era of the Sustainable Development Goals, make primary prevention the highest priority in national drug policies as it is ethically right, scientifically sound and economically smart;**
- **Use the International Standards on Drug Use Prevention to select the most effective interventions and thereby improve national prevention efforts;**
- **Allocate long-time funding for prevention programmes to ensure that they become sustainable over time. Prevention takes time, simply;**
- **Benefit from the competence that civil society organisations have in mobilizing communities and individuals and also benefit from good prevention programmes developed by these organisations.**

PARENTS FOR PREVENTION

INTRODUCTION

Good parenting is a powerful tool to prevent initiation of drug use and by that reducing prevalence rates and, ultimately, also to reduce drug-related harm. The role of parents is equally essential in preventing other harmful behaviours among adolescents. Prevention of many types of challenges can therefore be done in a comprehensive and balanced manner.

In the UNGASS outcome document parents are mentioned a few times as stakeholders. The International Standards on Drug Use Prevention are more elaborate in pointing at the potential of good parenting as essential already from pregnancy, through childhood, early adolescence and up to the late teens.
The International Standards offer the following explanation:

> "Parenting skills programmes support parents in being better parents, in very simple ways. A warm child-rearing style, where parents set rules for acceptable behaviours, closely monitor free time and friendship patterns, help to acquire personal and social skills, and are role models is one of the most powerful protective factors against substance use and other risky behaviours"[11].

In many corners of the world attempts have been made to mobilize parents for prevention of drug use and other youth-related problems, mostly by civil society organisations. Some of these programmes yield good results while others are more well-intended than effective. The International Standards point at the following characteristics to be associated with efficacy and/or effectiveness based on expert consultation:

- Enhance family bonding, i.e. the attachment between parents and children;
- Support parents on how to take a more active role in their children's lives, e.g., monitoring their activities and friendships, and being involved in their learning and education;
- Support parents on how to provide positive and developmentally appropriate discipline;
- Support parents on how to be a role model for their children;
- Organised in a way to make it easy and appealing for parents to participate (e.g. out-of-office hours, meals, child care, transportation, small prize for completing the sessions, etc.);
- Typically include a series of sessions (often around 10 sessions, more in the case of work with parents from marginalised or deprived communities or in the context of a treatment programme where one or both parents suffer from substance use disorders);
- Typically include activities for the parents, the children and the whole family;
- Delivered by trained individuals, in many cases without any other formal qualification.

In this chapter

We ask:

Have parent groups / good parenting been defined as a priority issue in national drugs policies, and are there initiatives taken to involve parents?

PARENTS FOR PREVENTION

FINDINGS

The material we have collected from 15 countries indicate that programmes to mobilize and support parents are largely ignored or not prioritized by most governments but left up to civil society organisations. This is too weak considering the potential of parents in prevention as described in the International Standards.

Most of the countries in our assessment seem to consider parents as only one of the many stakeholder groups that are relevant but not much more than that. Only four of the countries (Sweden, Zambia, Ghana, Kenya) seem to have defined parent mobilization as a national priority by having explicit strategies or programmes to involve and train parents.

Two countries are reported to have broader parenting programmes where drug prevention is one among several topics to be covered. There are good reasons to organize parenting programmes with such a broader thematic scope. Child development is a broad and complex process and the type of challenges may vary from one age group to the next and between cultures and districts, also within a country.

Seven-eight more countries have parenting programmes but organized by NGOs. In the US there are a large number of parenting programmes that could be used as inspiration for other countries. Many of these programmes are developed and run by civil society organisations.

Many NGO programmes for parents are often under-funded or covering smaller regions or population groups, often only single communities or school districts.

Recommendations

In order to improve the follow-up of UNGASS all Member States should:

- **Make mobilization of and support to parents a central part of national drug policies;**
- **Establish a national programme and a national unit/clearinghouse for support to local parent initiatives;**
- **Integrate mobilization of parents as an important element in broader community programmes for protection of children and youth;**
- **Draw lessons from the many NGO programmes for good parenting and collaborate with these NGOs.**

MOBILIZE COMMUNITIES

INTRODUCTION

Mobilization of communities, of a wide range of stakeholder groups and of many individual citizens is essential for bringing the UNGASS message about reducing drug-related harm out to people all over the world. Coalitions of concerned groups and individuals are effective in shaping values, influencing behaviour and promoting good drug policies.

A lot of initiatives from above are needed, both for demand and supply reduction, from national governments and national NGOs alike. However, such top-down initiatives must be combined with corresponding bottom-up actions.

The use of intoxicating substances, be it legal or illegal substances, is largely a collective phenomenon, a behaviour formed by the values and habits in the culture where we live and in the population group/s we belong to. We are simply influenced by the behaviour of others throughout our lives and, consequently, we also influence the behaviour of our friends, relatives and colleagues. Drug use is a learned behaviour for many people.

This makes it essential to establish or maintain community cultures where drug use is not a dominating behaviour, rather a marginal phenomenon with the lowest possible prevalence levels. The baseline is very positive, since only a minority of around five per cent has tested illegal drugs, according to the World Drug Reports, and only a small section of those who have tested have become regular users.

Collective, learned behaviours can best be changed by collective actions. This gives the communities a key role in reducing drug-related harm. The local community with its community leaders from many sectors is closest to the citizens, and has the power to both shape and protect local cultures and values.

MOBILIZE COMMUNITIES

Mobilizing communities are mentioned several places in the UNGASS outcome document, including in the preambular part:

> "We recognize, as part of a comprehensive, integrated and balanced approach to addressing and countering the world drug problem, that appropriate emphasis should be placed on individuals, families, communities and society as a whole, with a view to promoting and protecting the health, safety and well-being of all humanity".

However, communities are most often mentioned only as one among many stakeholders in longer lists of stakeholders that must be involved. No special call for action has been issued for communities, and there are good reasons to assume that most communities of the world have never heard about the challenge from UNGASS 2016.

In this chapter

We ask:

Is mobilization of communities a part of the national strategies to reduce drug-related harm and do the countries have national programmes for community involvement and for supporting active communities?

MOBILIZE COMMUNITIES

FINDINGS

All 15 countries in the survey have, in one way or the other, mentioned that contributions from communities, community-based organisations and individual citizens are important in the struggle for reducing drug-related harm. However, when one comes to operationalisation and implementation of this ambition most of the 15 countries have not come very far:

- Formulations on community mobilization are vague and not very binding;
- In most cases there are no plans or programmes to follow up verbal declarations with practical action;
- Most countries do not have any kind of national coordination unit that could recruit new communities, train community stakeholders, give technical advice or link active communities with each other;
- Funds are not allocated for community mobilization and in the few cases where such funds exist, they are small and only short-term allocations;
- Some few countries in the survey stand out as good examples for others. They have a national programme for community mobilization, a national unit to follow up and many communities involved in practical prevention work;
- NGOs in several countries have developed good and well-tested methods for building local coalitions for prevention of not only drug problems but also other types of risk behaviour among adolescents.

Recommendations

In order to improve the follow-up of UNGASS all Member States should:

- **Define community mobilization as a priority in their national policies, not only to combat drug problems but also to reduce other risk behaviours among adolescents;**
- **Establish a national clearinghouse or resource unit that can support local communities in various ways,**
- **Draw experiences from NGOs and Member States that have developed good models for forming and running local coalitions for drug prevention.**

SUPPORT SELF-HELP GROUPS
FOR DRUG USERS AND PEOPLE IN RECOVERY

INTRODUCTION

A variety of interventions should be available to people with substance use disorders to assure a continuity of treatment and care and that interventions are designed to meet individual needs. Informal community care consists of outreach interventions, self-help groups and recovery management, informal support through friends and family. According to the International Standards on the Treatment of Drug Use Disorders[12] organized groups of people who use drugs and people in recovery are key partners in community-based treatment and care networks.

Across the globe, self-help groups and support group services for drug users prove to be a successful tool for overcoming drug use disorders and reintegration into society afterwards. Such groups and programmes are thus a highly useful complement to more formal treatment services, and they provide much needed help in settings where few or no other options exist. Therefore, self-help groups should be available as a part of treatment and recovery services in all countries and seen as a part of an effective community-based treatment approach that utilizes all resources already available in the community.

In this chapter

We ask:

Do self-help systems for people with addiction and/or in recovery exist? Are self-help methods defined as part of national drug policy?

SUPPORT SELF-HELP GROUPS
FOR DRUG USERS AND PEOPLE IN RECOVERY

FINDINGS

The presence of self-help groups such as AA, NA or family clubs etc. have been reported from all countries participating in the study. However, a concrete record of beneficiaries or number of self-help groups is difficult to track as most of them are based on anonymity principle.

Self-help methods are rarely defined as part of national drug policy in the monitored countries. In a few of them there are mentions of self-help methods or alike without any elaborated specification regarding the system. The responsibility for self-help is mainly delegated to NGOs but with little financial or technical support provided by the governments. One country recognizes self-help groups as a valuable resource and plans to increase access to the self-help groups as they have proven to contribute to positive post-treatment developments.

Recommendations

In order to improve the follow-up of UNGASS all Member States should:

- **Integrate self-help groups in the system of community-based treatment and care;**
- **Recognize and define self-help groups in national drug policies and strategies;**
- **Enable access to quality-assured self-help groups by publishing an updated list of organisations and institutions providing self-help group services;**
- **Provide financial and technical support for organisations/institutions that offer self-help support to people who use drugs or who are in recovery, and to their families.**

FOCUS ON THE SPECIAL NEEDS OF WOMEN

INTRODUCTION

To tackle the world's drug problem it is absolutely vital to craft drug policies that consider and attend to the special needs of women and the great level of stigmatization that women are exposed to. Research, prevention programmes, treatment interventions for drug use disorders and alternative development programmes, as well as the criminal justice response to drug related offences, need to be gender sensitive.

In the UNGASS outcome document women is one of several cross-cutting issues. This means applying a gender-sensitive approach in relation to women as drug-offenders, users and relatives, and in relation to access to health, care and social services in prevention, primary care and treatment programmes. It is also important to

> "identify and address protective and risk factors, as well as the conditions that continue to make women and girls vulnerable to exploitation and participation in drug trafficking"[13].

Lastly the outcome document stresses the importance of mainstreaming

> "a gender perspective into and ensure the involvement of women in all stages of the development, implementation, monitoring and evaluation of drug policies and programmes, develop and disseminate gender-sensitive and age-appropriate measures that take into account the specific needs and circumstances faced by women and girls with regard to the world drug problem and, as States parties, implement the Convention on the Elimination of All Forms of Discrimination against Women"[14].

In this chapter

We ask:

Do the Member States have special policies and/or programmes that address women's needs relating to substance use problems?

FOCUS ON THE SPECIAL NEEDS OF WOMEN

FINDINGS

Several of the national reports highlight that drug use among women is much less prevalent than among men; for cultural, religious and other reasons. This probably, at least partially, explains why few countries have special programmes or interventions that relate or are aimed specifically at women's roles and needs, even though at policy level most countries refer to the importance of gender-sensitive approaches. On the whole, however, there is a lack of traces of the cross-cutting issue that gender is set out to be in the UNGASS outcome document.

Recommendations

In order to improve the follow-up of UNGASS all Member States should:

- **Take women's needs and roles into account as a cross-cutting issue in all drug policy areas; prevention, treatment and recovery;**
- **Address properly, both in policy and in specific interventions, women's needs as family members of drug users;**
- **Include women in policy-making, implementation and evaluation of drug policies and programmes.**

CONCLUDING REMARKS AND WAY FORWARD

The organisations affiliated to Drug Policy Futures are actively involved in drug policies and drug issues in their respective countries in all corners of the world. They have competence in all aspects of drug-related issues; prevention, early intervention, treatment, recovery, social re-integration as well as harm reduction.

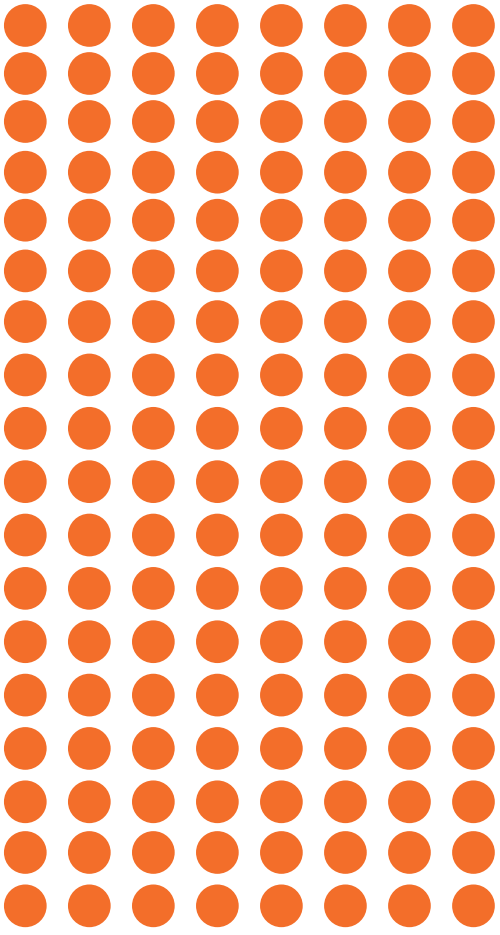
Our affiliated organisations consider the 2016 UNGASS outcome document as an excellent menu for broad, balanced and evidence-based national drug policies. We are fully committed to supporting Members States in their follow-up of UNGASS 2016.

At the same time we have to play our role as watch dogs, nationally and internationally. Are the commitments taken by Member States in New York in April 2016 followed up in national policies and by national programmes?

This is a question that we will seek to answer by our ongoing monitoring programme. This is the first report from the programme, and in the period up to 2029 we will produce two or three more reports of the same character.

The main conclusion in this report is that, with a few exceptions, we have found few signs that the UNGASS consensus has had a direct impact on national drug policies. We recognise of course the possibility that changes have been made on a more operational level than what our indicators have been able to uncover.

We also realize that not more than four years did pass from the closing of UNGASS in April 2016 till July 2020 when our data set was finalized. This report is launched in April 2021 which leaves us all eight more years for national implementation of the many good interventions presented in the UNGASS document "Our joint commitment to effectively addressing and countering the world drug problem".



Drug Policy Futures (DPF) is a global platform for a new drug policy debate based on health. We reject the simple dichotomy between a "war on drugs" on the one hand and "legalization" on the other. Instead we believe in engaging in an open dialogue about the strengths and weaknesses of global drug policies.
We will advocate for evidence-based strategies to promote public health, safety and the well-being of society, including those addicted to drugs and their families. Drug Policy futures has members from all continents. They cover a wide range of services from prevention, early intervention, treatment, harm reduction, social reintegration and recovery. Our strength is a rich mixture of organizations that work both nationally and internationally, as well as on grassroot level with children, women, men, drug addicts, prisoners, recovered drug users and professionals.

DRUG POLICY FUTURES

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14. ibid

ATTACHMENTS

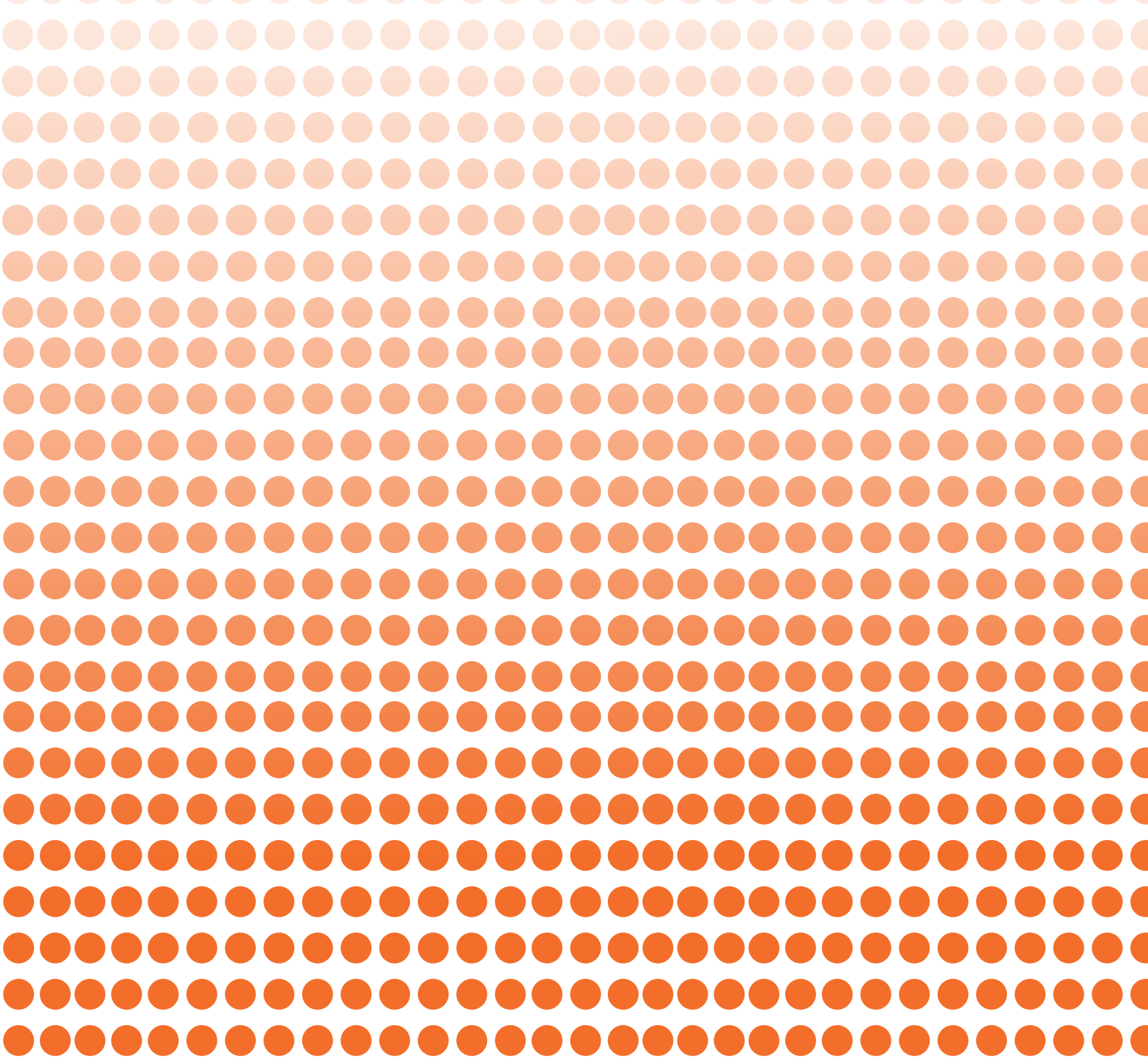
Action areas and indicators

Action area	#	Indicator
1. National policies and strategies to guide work to reduce drug-related harm	#1	(Country) has a national drug plan/strategy to guide its work to reduce drug-related harm
	#2	If no on #1: (Country) has other types of official documents to guide its work to reduce drug-related harm
	#3	The national drug strategy takes a comprehensive and balanced approach to reducing drug-related harm, including prevention, early intervention, treatment
2. Reduce drug use prevalence	#4	Low or reduced drug use prevalence is defined as a priority for national drug policies
	#5	(Country) has a system in place to track changes in prevalence figures
	#6	There is a low or a reduced drug use prevalence in the general population and/or among youth in particular
3. Invest in prevention	#7	The government and its institutions invest money and human resources in prevention of drug use among adolescents
	#8	Prevention policies and programmes make reference to best available evidence
	#11	Giving accurate information on the risks of drug use and developing of life-skills is part of school curriculums for relevant age groups.
4. Mobilize communities	#9	To mobilize local communities has been given a defined place in national drug policies
	#10	A national programme for mobilizing local communities exists
5. Parents in prevention	#12	Programme/s to assist parents in their parenting roles exist
6. Prioritize early intervention and assistance to vulnerable groups.	#13	Early interventions have been defined as a priority for national drug policies.
	#14	The education system has a plan or defined routines for how to identify and assist vulnerable children and youth
7. Important issue, but our material is not very strong on this issue.	#15	The primary health care system has defined screening and brief interventions as one of its tools to identify and address substance use disorders at an early stage.
8. Offer treatment, rehabilitation and harm-reduction alternatives	#16	(Country) has national data to show treatment coverage for drug users.
	#17	(Country) offers a wide range of treatment alternatives to meet the various needs of drug users.
9. Foster reintegration of people who use drugs	#18	(Country) has a plan or a system for reintegration of former addicts into society after treatment
10. Support self-help groups for drug users and people in recovery	#19	Self-help systems for addicts and former addicts exist
	#21	Self-help methods are defined in as parts of a national drug policy
11. Focus on the special needs of women	#20	(Country) has special policies and/or programmes that address women's needs relating to substance use problems
12. Support Alternative Development	#22	The country supports Alternative Development as a strategy to reduce drug problems
13. Develop and implement alternatives to incarceration	#23	Alternatives to punishment and incarceration is being (increasingly) used as a reaction to minor drug offences
14. Implement the principle of proportionality in sanctions	#24	The country has abolished the use of capital punishment for drug-related crime or imposed a moratorium on the execution of death sentences for such offenses
15. Capacity building	#25	Knowledge on drugs and drug use prevention is part of training programmes for professional groups, including doctors, health and social workers, teachers and police.

ATTACHMENTS

Countries and national focal points in this first monitoring exercise

Countries	Focal points	Region
Kenya	SCAD: The Students' Campaign Against Drugs	Africa
Zambia	SHARPZ: Serenity Harm Reduction Programme Zambia	Africa
Ghana	VALD: Vision for Alternative Development	Africa
Nigeria	Nigeria Green Crescent	Africa
Uganda	UYDEL: Uganda Youth Development Link	Africa
DR Congo	CFGL: Council of Facilitators from the Great Lakes	Africa
Pakistan	KKAWF: Karim Khan Afridi Welfare Foundation	Asia
Sri Lanka	ADIC:Alcohol and Drug Information Centre	Asia
India	Fourth Wave Foundation	Asia
Nepal	CWIN: Child Workers in Nepal	Asia
USA	DFAF: Drug Free America Foundation CADFY: Community Alliances for Drug Free Youth	North America
Florida, USA	DFAF: Drug Free America Foundation CADFY: Community Alliances for Drug Free Youth	North America
Sweden	Narkotikapolitiskt Center	Europe
Norway	Actis - Norwegian Policy Network on Alcohol and Drugs	Europe
Italy	San Patrignano	Europe



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